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Psychological factors in the irritable bowel syndrome

SIR,—We were sorry to read in the Progress Report by Creed and Guthrie,[1] the statement that we had used the Beck Inventory wrongly for screening depression in surgical outpatients, taking a cut off point for depression of 5 instead of 14.[2]

In fact we used a simplified form of the Beck Depression Index, for which the range of normality is 0–4. 5–7 indicating mild, 8–15 moderate and over 15 severe depression. Had Creed and Guthrie read our article more carefully, they would have found that we correctly used the criteria of Beck and Beck,[3] and our finding of a 50% incidence of depression in gastrointestinal outpatients, and 68% in the irritable bowel syndrome, remains valid. They would also have learnt that the majority of patients were medical, and not surgical, outpatients.

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Reply

SIR,—Smith and Harvey are right to draw attention to the fact that they had used a shortened form of the Di-Beck questionnaire so that our criticism of their specific cutoff point does not hold; but we would still reject their claim that they have accurately demonstrated rates of depression of 50% and 68% in gastrointestinal and IBS patients respectively.

In their paper Rose *et al*[1] aimed 'to establish the number of patients suffering from depression' among new referrals to a gastrointestinal clinic. There are several reasons why the shortened Di-Beck questionnaire did not allow them to do this accurately. First, it is not a diagnostic tool but a measure of severity of depression.[2] Second, any selfadministered questionnaire cannot be used as a substitute for clinical assessment and should therefore be validated by a use of standardised interview.[3] We are not aware of any such validation of the shortened Di-Beck against clinical interviews among gastrointestinal outpatients, but there is evidence that 14 of the 21 items of the original questionnaire discriminated poorly between depressed and non-depressed patients in a general medical unit[4] and many of these items have been included in the shortened form.

Selfadministered questionnaires tend to overestimate the prevalence of depression in general medical patients because somatic symptoms and social dysfunction score on the questionnaire even when these are not the result of depressive illness.[5] In the case of the shortened Di-Beck, a score of 7 could be achieved by the patient who reports 'my appetite is much worse now' (2 points), 'I get too tired to do anything' (3 points), and 'I have to push myself hard to do anything' (2 points). Such complaints could be attributable to physical illness, and are common

among IBS patients without necessarily indicating psychiatric disorder. A more conservative estimate of depression among Rose *et al's* patients would therefore use a cutoff point of 8 or more, which would greatly reduce the overall prevalence of depression from their figure of 50%.

Rose *et al* compared their results with those of Macdonald and Bouchier[6] who did use a standardised interview before making a psychiatric diagnosis. These workers found that only 20% of their sample had depression (in 16% it was rated as severe); a further 22% had anxiety (which is not measured by the Di-Beck). Among the non-organic group the figures were 25% for depression and 22% for anxiety. The other studies quoted in our review paper suggest that these are much more accurate figures than those produced by the Rose *et al's* method.

We applaud Rose *et al's* attempts to highlight the prevalence of depressive illness in general medical and gastrointestinal patients, and agree completely with the view 'that early diagnosis of psychiatric disorder . . . may lead to a shorter period of illness'. One of the main points of our review article however, was that the research instrument and the cutoff points must be chosen with extreme care, otherwise the prevalence of psychiatric disorder will be overestimated.

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Continuous oesophageal pH-monitoring

SIR,—We were very interested in the recent article by McLauchlan and coworkers[1] comparing different electrodes for 24 hour pH monitoring. This study shows very clearly better results obtained with glass electrodes compared with antimony electrodes and also the differences obtained when different electrodes are used. We prefer to use glass electrodes with a remote skin reference electrode because of the very small external diameter (1·6 mm; Microelectrodes Inc. M 506), as we are especially interested in infants younger than four months. In our opinion the paper by McLauchlan stresses the necessity to establish normal physiological ranges of gastroesophageal reflux for each group of patients, or for each technique. The physiological incidence of gastroesophageal reflux will be different according to the position,[2] and age[3] of the infants. In infants, results will be dependent on the formula administered to the infant,[4] with or without milk thickening agents.[5] The type of material used for registration (continuous, one measurement stored in a memory every 5, 7·5 seconds, or every minute), and the pH electrode[1] used are of course other factors that can influence the data. We would like to stress the necessity for each team to establish normal ranges for their method and for their population data considered as within physiological ranges for a six month old infant investigated with a glass electrode with a remote reference electrode can be 'pathological' for a one month old baby investigated with a glass electrode with a combined sensing and reference electrode.

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